Arizona Health Care Cost Containment System
Arizona Department of Health Services
Division of

Behavioral Health Services

Report for Contract Year 2006

External Quality Review Organization Annual Report

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Arizona Health Care Cost Containment System (AHCCCS)
Contract Year 2006
EQRO Annual Report
Behavioral Health Services

EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) administers the Arizona Medicaid program established under Title XIX of the Social Security Act. AHCCCS contracts with the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) for the delivery of services provided to its acute-care members, and has a significant oversight role. The AHCCCS contract with ADHS/DBHS stipulates the standards for access, structure and operations, and quality measurement and improvement for Behavioral Health Services (BHS).

The Federal Balanced Budget Act of 1997 (BBA) mandated that states ensure the delivery of quality health care by all their Medicaid managed care contractors. The BBA requires states to submit an annual External Quality Review (EQR) report to the Centers for Medicare & Medicaid Services (CMS) for each Medicaid Managed Care Organization (MCO) and Prepaid Inpatient Health Plan (PIHP). The ADHS/DBHS behavioral health managed care services fit the CMS definition of a PIHP, thus requiring external review.

ADHS/DBHS subcontracts with Regional Behavioral Health Authorities (RBHAs) to either provide covered behavioral health services directly or to secure a network of providers, clinics, and other appropriate facilities and services to deliver behavioral health services to Medicaid-eligible members within their contracted geographic service area (GSA). ADHS/DBHS has Intergovernmental Agreements for Tribal RBHAs (TRBHAs) with some of Arizona's American Indian Tribes for provision of behavioral health services to persons living on the reservations. Each Arizona Medicaid member either chooses or is assigned to an acute-care MCO for episodic and preventive health care. If the member requires behavioral health services, the acute care plan typically refers the member to the appropriate RBHA/TRBHA. The member goes through the RBHA's intake evaluation process and then receives the needed behavioral health services through the RBHA system of contracted providers. A Medicaid member also may self-refer directly to a RBHA/TRBHA or its contracted provider for behavioral health care.

For publicly funded behavioral health services, Arizona is divided into six (6) GSAs served by four (4) RBHAs: ValueOptions, Community Partnership of Southern Arizona (CPSA), Northern Arizona Behavioral Health Authority (NARBHA), and Cenpatico Behavioral Health of Arizona.

AHCCCS monitors and evaluates ADHS/DBHS compliance with state and federal regulations through program specific performance measures, performance improvement projects (PIPs), review and analysis of periodic reports required by the contract, and an annual Operational and Financial Review (OFR). In compliance with the 1997 BBA, AHCCCS contracted with an External Quality Review Organization (EQRO) to draft a report of the AHCCCS findings related to quality monitoring of the BHS system. The BBA specifies three (3) mandatory External Quality Review (EQR) activities, including validation of a selected performance measure, validation of a selected PIP, and

monitoring compliance with federal managed care regulations through the annual OFR. These three activities may be completed by different entities, but a single EQRO must prepare the annual report for submission through AHCCCS to CMS.

This EQRO Annual Report on the ADHS/DBHS PIHP for Title XIX managed behavioral health services is for contract year 2006 (CY 2006) from July 1, 2005 through June 30, 2006. AHCCCS performed the required monitoring of ADHS/DBHS compliance with federal and state laws regarding managed care systems through its OFR. AHCCCS selected the performance measure and PIP for validation by the EQRO, with all three required elements incorporated by the EQRO into this annual report.

The performance measure selected for validation was one of the three parts of the Access to Care/Appointment Availability measure routinely monitored by ADHS/DBHS. This is the measure of the extent to which routine assessment appointments were scheduled within seven (7) days or less of referral or request for behavioral health services. This access measure was the indicator for a performance improvement project (PIP) that was initiated in CY 2003 and completed in CY 2006, and this PIP is the one selected for EQR validation in CY 2006.

The data source for this measure of access selected for EQR has historically been the paper RBHA provider referral logs. However, starting in the second quarter of CY 2006, the RBHAs began compiling the data electronically for submission to ADHS/DBHS.

Computation of the measure was performed by random samples of data without errors in the mandatory fields, stratified by RBHA and by adults and children. Sample size was sufficient to allow a 90% confidence level and five (5)% margin of error at the RBHA level at the beginning of the PIP, but was later increased to a 95% confidence level and a five (5)% margin of error. ADHS/DBHS reviewed and recalculated sample sizes every year to ensure adequate representations of total referrals. Reporting of this measure was through Quarterly Contractor Performance Improvement Activity Reports. ADHS/DBHS required RBHAs to take corrective action for error rates in excess of five (5)%. For RBHAs whose error rate exceeded five (5)% for two (2) consecutive quarters, ADHS/DBHS took corrective action, up to and including sanctions.

In its contract with ADHS/DBHS, AHCCCS established three (3) levels of performance pertaining to required measures. They are Minimum, Goal, and Benchmark. ADHS/DBHS was required to meet, and ensure that each subcontractor met, the AHCCCS Minimum Performance Standard. ADHS/DBHS and its subcontractors were expected to continually improve performance measure results from year-to-year and strive to meet the ultimate or Benchmark Performance Standard. For the measure of the extent to which routine assessment appointments were scheduled within seven (7) days or less of referral or request for behavioral health services, the CY 2006 Minimum Performance Standard was 85%, the CY 2006 Goal was 90%, and the CY 2006 Benchmark was 95%.

The PIP started in December 2003 and the first year was the baseline measurement year. The proposed PIP objectives were as follows.

- To examine the availability of routine appointments within the prescribed time frame
- To identify barriers to appointment availability
- To develop a mechanism for systematic reporting of appointment availability across RBHAs

The Access to Care PIP Final Study Report was submitted by ADHS/DBHS to AHCCCS January 17, 2007. Substantial improvement in compliance rates occurred over the 3.5 year PIP timeframe.

- For CY 2003, yearly state-wide compliance was 77.47%
- For CY 2004, yearly state-wide compliance was 87.79%
- For CY 2005, yearly state-wide compliance was 91.46%
- For CY 2006, yearly state-wide compliance was 95.5%

The baseline yearly compliance rate was less than the required Minimum Performance Standard. In the first (CY 2004) and second (CY 2005) PIP intervention years, yearly compliance rates met or exceeded the Performance Standard Goal and the yearly compliance rate exceeded the Benchmark Performance Standard in CY 2006. This continued improvement in yearly state-wide compliance rates was deemed to have demonstrated that high state-wide performance improvement had been achieved and sustained in a manner sufficient to bring an end to the PIP. This performance measure will continue to be computed and reported in the Quarterly Contractor Performance Improvement Activity Reports for the foreseeable future.

The Operational and Financial Review (OFR) tool used by AHCCCS for reviewing ADHS/DBHS contained 49 standards/substandards from six (6) program areas including Delivery System, General Administration, Grievance System and Member Rights, Quality Management, Utilization Management, and Recipient Services. Findings were documented for each standard/substandard and a compliance rating assigned. Standards/substandards were rated in Full Compliance if 90% to 100% of the requirements were met. Where 80% to 90% of the requirements were met, a rating of Substantial Compliance was assigned. When 70% to 80% of the requirements were satisfied, a Partial Compliance rating was recorded. If less than 70 % of the requirements were met, a Non-compliance rating was given. If the standard was not applicable for some reason, ADHS/DBHS was Not Rated.

For the CY 2006 OFR, ADHS/DBHS was rated in Full or Substantial Compliance for 39 (80%) of the 49 standards/substandards. One (1) substandard received a Partial Compliance rating, and one (1) was Not Rated. Non-compliance ratings were given in eight (8) instances. Seven (7) of the eight (8) ratings of Non-Compliance were in the Quality and Utilization Management areas, with Recipient Services receiving one Non-

compliance rating. AHCCCS required ADHS/DBHS to submit Corrective Action Plans (CAPs) for eight (8), (16.3%) of the standards/substandards.

I. INTRODUCTION

A. Background

Medicaid was established in 1965 under Title XIX of the Social Security Act. It is a federal and state sponsored program for financing medical, long-term care, and other optional services for low-income legal residents of the United States. Medicaid is administered at the federal level by the Centers for Medicare & Medicaid Services (CMS) which pays the federal share of qualifying state Medicaid expenditures. States design and administer Medicaid within federally-defined boundaries relating to eligibility, benefits, coverage, and provision of care. Some options are specifically described in the federal law and CMS has authority to "waive" certain statutory requirements so a state can, for example, cover certain eligibility groups or benefits that could not otherwise be covered under Medicaid. There are different types of Medicaid waivers, with Section 1115 waivers allowing the most extensive departures from federally-defined boundaries. These Section 1115 research and demonstration waivers are granted for comprehensive programs of health reform and may involve restructuring a state's Medicaid program as well as the terms and conditions of federal funding.

Medicaid programs have increasingly moved toward managed care arrangements as delivery systems for Medicaid beneficiaries. Medicaid managed care typically requires the Medicaid beneficiary to enroll with a specific Managed Care Organization (MCO) that is under contract with the state Medicaid program to accept certain responsibilities for providing and authorizing needed medical care. Some state Medicaid agencies find it advantageous to arrange for certain services, such as behavioral health care, to be "carved out" of MCO contracts.

Arizona's Medicaid Program under Title XIX began in October 1982, when it implemented the Arizona Health Care Cost Containment System (AHCCCS) as a Section 1115 demonstration project. From October 1982 until December 1988, AHCCCS covered only acute care services and 90-day post-hospital skilled nursing facility coverage for Medicaid recipients. AHCCCS established a capitated program, distinct from the capitated acute-care program, to serve developmentally disabled populations in December 1988, and expanded it to include long-term care for elderly and physically disabled Medicaid recipients in January 1989.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) was created in 1986 to serve as the Arizona State authority for coordination, planning, administration, regulation, and monitoring of all facets of the Arizona public behavioral health system. ADHS/DBHS oversees the behavioral health services available to all state-supported programs, not just Medicaid, although Medicaid is the largest single category of eligible members for these services.

AHCCCS, the single state agency for Arizona's Medicaid program, contracts with ADHS/DBHS as a Prepaid Inpatient Health Plan (PIHP) to administer capitated behavioral health services to Medicaid recipients in the acute care program. In October

1990, AHCCCS began phasing in comprehensive behavioral health services for Medicaid recipients, beginning with coverage for seriously emotionally disabled children under age 18 who require residential care.

Over the next five years behavioral health coverage was extended to all Medicaid-eligible persons in Arizona. During Contract Year (CY) 2006, July 1, 2005 through June 30, 2006, 96,773 Title XIX Medicaid recipients received services through the publicly funded behavioral health system.[1] This represents approximately 10% of total Medicaid recipients in Arizona.

ADHS/DBHS subcontracts with Regional Behavioral Health Authorities (RBHAs) to provide covered behavioral health services directly or to secure a network of providers, clinics, and other appropriate facilities and services to deliver behavioral health services to Medicaid-eligible acute-care members within their contracted GSAs. RBHAs function for the provision of behavioral health services in a way similar to Managed Care Organizations. Arizona Medicaid covers a full range of behavioral health care services, including prevention programs for children and adults, and the continuum of services for adults with general mental health and substance abuse disorders, children with serious emotional disturbance, and adults with serious mental illness. Covered behavioral health services include treatment, rehabilitation, support, medical, day programs, inpatient, and residential services.

For the provision of behavioral health services, Arizona is divided into six GSAs served by four RBHAs.

- ValueOptions serves Maricopa County
- Community Partnership of Southern Arizona (CPSA) serves Pima, Graham, Greenlee, Santa Cruz, and Cochise Counties
- Northern Arizona Behavioral Health Authority (NARBHA) serves Mohave, Coconino, Apache, Navajo, and Yavapai Counties
- Cenpatico Behavioral Health of Arizona (Cenpatico) serves Pinal, Gila, Yuma, and La Paz Counties

These RBHAs, other than ValueOptions for Maricopa County, are the result of new contracts effective July 1, 2005 at the beginning of CY 2006. RBHA contracts run for three years, with an option to extend for two more years based on performance. As a result of the competitive process for RBHA contracts, Cenpatico replaced the EXCEL group that formerly held the contract in western Arizona for Yuma and LaPaz counties. Cenpatico also replaced the Pinal Gila Behavioral Health Association (PGBHA) as of July 1, 2005 for provision of behavioral health services in Pinal and Gila counties. ADHS/DBHS extended ValueOptions' contract for provision of behavioral health services in Maricopa County by two months from July 1 to August 31, 2007, with the winner of the new contract expected to be announced in mid-May, 2007. ValueOptions has been providing behavioral health services in Maricopa County since 1998. An independent evaluation team is reviewing proposals from bidders to provide behavioral health services in Maricopa County beginning September 1, 2007.

In addition to the RBHAs above, ADHS/DBHS has Inter-governmental Agreements for Tribal RBHAs (TRBHAs) with some of Arizona's American Indian Tribes to provide behavioral health services to persons living on the reservations. A map showing each of Arizona's behavioral health GSAs, RBHAs, and TRBHAs during CY 2006 is included in the Appendix.

The behavioral health services provided are predominantly outpatient. The covered behavioral health services include but are not limited to, behavioral management, case management, emergency/crisis services, emergency and non-emergency transportation, evaluation and screening, individual, group and family counseling, inpatient psychiatric care, partial care, psychosocial rehabilitation, psychotropic medication, respite care and therapeutic in-home care services. Arizona also provides limited services to Title XIX members age 21 through 64 in Institutes for Mental Diseases.

Each Arizona Medicaid member either chooses or is assigned to an acute care MCO for episodic medical and preventive health care needs. If the member requires behavioral health services, they are typically referred by that acute care plan to the appropriate RBHA. The member goes through the RBHA's intake evaluation process, and then receives the behavioral health care needed through the RBHA system of contracted providers. Medicaid members may self-refer directly to a RBHA or its contracted provider for behavioral health services.

The Federal Balanced Budget Act of 1997 (BBA) mandated that states ensure the delivery of quality health care by all their Medicaid managed care contractors. CMS published the finalized BBA regulations (42 CFR 438 et. seq.) on June 14, 2002,[2] which included specifications for quality assessment and performance improvement strategies that the state must comply with.

AHCCCS includes in its contract with ADHS/DBHS those elements that are required to monitor and measure quality, timeliness, and access to care in accordance with federal and state regulations. These elements include certain program-specific performance measures, performance improvement projects, an Operational and Financial Review (OFR) that monitors contractor compliance with federal and state laws regarding managed care systems, and periodic reports as required in the contract.

The contract between AHCCCS and ADHS/DBHS for the provision of Medicaid behavioral health services stipulates the standards for access, structure and operations, and quality measurement and improvement. The AHCCCS Medical Policy Manual (AMPM), as well as other AHCCCS policies and manuals, are incorporated by reference as a part of the contract and provide more detailed information and requirements. The BBA requires AHCCCS to submit an annual external quality review report to CMS.[3]

AHCCCS has mechanisms to ensure that ADHS/DBHS maintains information systems that collect, analyze, integrate, and report data to achieve AHCCCS objectives. ADHS/DBHS and its subcontractors are required to have claims processing and

management information systems to collect service-specific procedures and diagnosis data, encounters, and records of remittances to providers.

Data timeliness, accuracy, and completeness are assessed, and AHCCCS performs extensive data validation as a condition of its 1115 Waiver. A major source of behavioral health outcome measures is the annual Mental Health Statistics Improvement Program (MHSIP) consumer survey, which ADHS/DBHS participates in to determine consumer satisfaction related to the behavioral health system.

AHCCCS developed a formal Quality Initiative and Performance Improvement Plan in 1994 and continues to be an innovator and national leader in the area of Medicaid Managed Care. The AHCCCS Quality Strategy specific to Medicaid Managed Care was established in 2003 and the most recent Quality Assessment and Performance Improvement Strategy was published by AHCCCS in December 2006. "It is a coordinated, comprehensive, and pro-active approach to drive quality through creative initiatives, monitoring, assessment, and outcome based performance improvement. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. It is designed to identify and document issues related to those standards, and encourage improvement through incentives, or where necessary, through corrective actions."[4]

B. Description of EQRO Activities

The BBA requires that state Medicaid agencies provide CMS with an annual, external independent review of access to, timeliness of, and the quality outcomes of services provided by MCOs.[2] The CMS Final Rule for External Quality Review (EQR) of Medicaid Managed Care, which implemented this BBA provision, requires an annual, independent, external review of Prepaid Inpatient Health Plans.[3] ADHS/DBHS is considered by CMS to be a PIHP for the provision of Medicaid managed behavioral health services in Arizona.

The CMS Final Rule further requires that the EQRO report incorporate a review of the three mandatory activities consistent with the associated published protocols as follows.[4]

- Validation of Performance Measures
- Validation of Performance Improvement Projects (PIPs)
- Determination of MCO/PIHP Compliance with federal Medicaid Managed Care Regulations

These EQR activities can be performed by one or more organizations, but each of these three required activities must be incorporated into a single annual report by one EQRO. For the behavioral health managed care system for Title XIX members in Arizona, AHCCCS, the state Medicaid Agency, performed the required EQR activities related to the third protocol above and provided the information to the EQRO. ADHS/DBHS provided the EQRO with electronic data used to compute the selected performance measure for the purpose of validation.

AHCCCS has contracted with HCE QualityQuest (QQ) to produce the EQRO Annual Report for Behavioral Health Services. This annual EQRO technical report includes strengths, weaknesses, and recommendations for ADHS/DBHS. The EQRO findings and recommendations are submitted to ADHS/DBHS and CMS by AHCCCS and used to contribute to ongoing AHCCCS Quality Assessment and Performance Improvement Strategy development and the ADHS/DBHS quality improvement activities. The Arizona EQRO Annual Reports are available online on the AHCCCS Web-site and thus are available for review by behavioral health care recipients, Arizona stakeholders, other state Medicaid programs, and the community at large.

C. State Quality Initiatives

AHCCCS has formulated five year strategic goals with the following objectives.[5]

- Using nationally recognized protocols, standards of care, and benchmarks
- Using a system of rewards for physicians, in collaboration with contractors, based on clinical best practices and outcomes
- Emphasizing disease management
- Improving functionality in activities of daily living
- Planning patient care for the special needs population
- Increasing the emphasis on preventative care
- Identifying and sharing best practices
- Exploring Centers of Excellence
- Continuing to use strategic partnerships to improve access to health care services and affordable health care coverage
- Collaborating with sister agencies, contractors, and providers to educate Arizonans on health issues
- Assuring effective medical management of at-risk and vulnerable populations
- Building additional capacity in rural and underserved areas
- Collaborating on border health care issues
- Enhancing Web-based self-help and health/medical information applications
- Replacing the mature AHCCCS Prepaid Medical Management Information System (PMMIS) to enhance functionality
- Enhancing the data warehouse to store data from various sources and systems to provide more robust retrieval and reporting capabilities
- Using adult and youth services for families MHSIP client satisfaction surveys, allowing Arizona to continue to benchmark behavioral health outcomes with other states

These AHCCCS objectives are aligned with the Medicaid Quality Strategy recently developed by CMS.[6] The CMS key strategies include the following.

- Evidence-based care and quality measurement
- Payment aligned with quality

- Health information technology
- Partnerships
- Information dissemination, technical assistance, and sharing of best practices.

ADHS/DBHS has a strategic plan that incorporates elements of CMS' and AHCCCS' strategies, as well as objectives specific to behavioral health.[7] These ADHS/DBHS objectives for CY 2006 is as follows.[7]

- Improve suicide prevention and treatment services in collaboration with other organizations
- Collaborate with the primary care system to improve services to those with serious co-occurring physical and behavioral health disorders
- Collaborate with stakeholders to reduce the stigma associated with being a behavioral health recipient
- Actively involve behavioral health recipients and families in the design, implementation, and monitoring of the behavioral health system
- Develop, implement, and monitor an individual assessment and plan of care with every consumer and family
- Implement the federal grievance system requirements
- Implement the statutory expansion of the oversight responsibilities of Regional Human Rights Committees to include the non-Medicaid, non-Seriously Mentally Ill population
- Improve access to culturally competent behavioral health care
- Improve access to care in rural and geographically remote areas
- Expand and enhance the state-wide network of providers
- Implement the early childhood assessment
- Execute a systematic method to implement best practices across the state-wide publicly-funded behavioral health system
- Continue to develop and implement the best possible publicly-funded behavioral health system
- Improve submission of claims and encounters submitted by providers and RBHAs
- Improve the information and reports available to meet community needs
- Improve the timeliness, completeness, accuracy, and consistency of enrollment and disenrollment transactions and demographic data sets

These Strategic Plan objectives were assigned action steps, measures, and task leaders. Strategic objectives are tracked through updates and submitted by ADHS/DBHS to AHCCCS with the Quarterly Contractor Performance Improvement Activity Reports.

References

[1]Arizona Department of Health Services, Division of Behavioral Health Services, and Arizona State Hospital, Annual Report, Fiscal Year 2006, December 28, 2006.

[2]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 – Managed Care http://www.gpoaccess.gov/cfr/index.html.

[3]Centers for Medicare & Medicaid Services, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations (Final Rule. Federal Register, 68(16): 3585-638), January 24, 2003.

[4]Centers for Medicare & Medicaid Services, Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. February 11, 2003.

[5]State of Arizona, Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2006.

[6]Centers for Medicare & Medicaid Services, Medicaid/SCHIP Quality Strategy. http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/.

[7]Arizona Department of Health Services, Division of Behavioral Health Services, Strategic Plan. http://www.azdhs.gov/bhs/bh_topics.htm.

II. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE MEASURE

ACCESS TO CARE: APPOINTMENT AVAILABILITY FOR ROUTINE ASSESSMENT WITHIN SEVEN (7) DAYS OF REFERRAL OR REQUEST FOR BEHAVIORAL HEALTH SERVICES

A. Objectives

This external review had the objective of being consistent with the CMS protocol for Validation of Performance Measures[1] by identifying potential issues with the process and techniques used by ADHS/DBHS in collecting, calculating, and reporting the state-wide performance measure for Access to Care: Appointment Availability for Routine Assessment Within Seven (7) Days of Referral or Request for Behavioral Health Services. Based on CMS definitions, ADHS/DBHS is a Prepaid Inpatient Health Plan (PIHP) for whom annual external review is required. ADHS/DBHS is the only behavioral health PIHP in Arizona, and the external review is therefore focused at the ADHS/DBHS level rather than on RBHAs and their providers.

Validation, in the context of the CMS protocol for performance measure validation, refers to determining whether a performance indicator actually measures what it purports to measure. Typical activities include verifying whether the reported results of the performance measure were based on accurate source information and/or were calculated appropriately. The reliability of performance measurements can be tested by having an independent external reviewer repeat calculations to determine the comparability of the results.

B. Description of Data Collection Methodology

The performance measure was the percentage of referrals or requests for behavioral health services offered appointments within seven (7) days. The numerator was the number of sample referrals that met the requirement of appointment availability within seven (7) days. The denominator was the total number of sample referrals reviewed. Results were compared with the established standards for compliance. The Minimum Performance Standard was 85%, the Goal was 90%, and the Benchmark was 95%.[2]

The annual sample size was calculated based on referral numbers reported by each GSA for the previous fiscal year and divided by four (4) to obtain the quarterly sample. Each quarter a sample was drawn for each GSA, and split proportionately by age (adults and children), by a sampling procedure using every *n*th case. Samples were drawn from Title XIX/XXI members who were referred for routine assessment during the quarter.

In CY 2006, AHDS/DBHS was in the process of transitioning to an electronic system for capturing data from RBHA referral logs necessary to compute this measure of access to care. Samples started being selected using a computer program and referrals with errors were omitted from the samples. Access to Care Referral Log Specifications and a

Uniform Referral Log Column Layout had been developed previously and ADHS/DBHS began calculating error rates during autumn of 2005 in an effort to improve data quality and integrity.

The percentage of data errors and blanks were calculated on a monthly and quarterly basis. Formal actions were taken for errors in excess of five (5)% for two consecutive quarters. ADHS/DBHS required RBHAs to perform an analysis when there was a decrease of five (5)% or more in performance on this measure from one quarter to the next and an improvement plan was required in such instances to improve sustainability of performance.[3]

As of the second quarter of CY 2006, RBHAs submitted information previously contained in the referral logs to ADHS/DBHS in Comma Delimited Text Format according to ADHS/DBHS referral log specifications and file layout. This data was placed on the network server where it could be accessed by ADHS/DBHS and the RBHAs. Policies and procedures to protect confidentiality were updated to encompass the move to electronic data for this measure.[3]

According to the ADHS/DBHS Performance Improvement Specification Manual, four fields were mandatory for calculation of the measure, and these were flagged to denote any errors as follows.[4]

- Title XIX/XXI if blank
- Program Type if blank
- Referral Date if the date had an error or was blank
- Date of First Offered Appointment if the date had an error or was blank

The number of days between the referral date and the date of the first offered appointment was calculated by subtracting the referral date from the first offered appointment date. Referrals with less than or equal to seven (7) days from referral date for first appointment offered date were in compliance and referrals with eight (8) or greater days were out of compliance.

Monthly data were aggregated and analyzed for quarterly reporting to AHCCCS through the Quarterly Contractor Performance Improvement Activity Reports. Data was aggregated on an annual basis for yearly review of the performance measure.

At the end of each fiscal/contract year, the sample size was planned to be sufficient to allow for statistically valid representation of the annual results using a 95% confidence level and 5% margin of error. This was not achieved when referrals during a given year increased substantially compared to the previous year. This situation occurred during CY 2006, and sample sizes for the third and fourth quarters were re-calculated based on referral numbers for the previous four quarters.

The CY 2006 data reported by ADHS/DBHS pertaining to this measure is shown in Table 1.

Table 1
Access to Care: Appointment Availability for Routine Assessment
State-wide Compliance Rates Using Samples

CY 2006	Total Referrals	Sample Size	Appointments Available Within 7 Days of Referral	Appointments Available Exceeding 7 Days of Referral	Percentage of Appointments Available Within 7 Days of Referral
Quarter 1	15,752	555	523	32	94.23%
Quarter 2	15,947	555	504	51	90.81%
Quarter 3	13,982	549	539	10	98.12%
Quarter 4	13,147	542	535	7	98.70%
TOTAL	58,828	2,201	2,101	100	95.50%

C. Validation of Measure

The EQRO planned to pull a sub-sample from the sample cases shown above and request the referral log source documents, in order to validate the accuracy of the data. DBHS was not able to provide the hard copy of the referral logs within a timely manner and therefore failed to provide a complete and comprehensive set of valid and reliable data to conduct a validation of the performance measure. Discussions with ADHS/DBHS staff revealed that submittal of this data transitioned from a manual to an automated process during one quarter. This change is recognized as a more efficient process to mine this data; however the transition may have resulted in collection errors for that specific timeframe.

ADHS/DBHS provided the EQRO with a compact disc in Comma Delimited Text Format containing electronic data for total referrals for routine assessment from July 1, 2005 through June 30, 2006 (CY 2006). The EQRO found that this Compact Disk contained 58,484 referrals, rather than the 58,828 expected based on Table 1. It was explained that there had been problems with one RBHA having included data during the first two quarters for referrals that were not Title XIX/XXI members and those referrals had been removed for the total referrals disc.

The EQRO computed compliance rates from the universe of data for comparison with the compliance rates computed from the sampling data by ADHS/DBHS. A CY 2006 "total referrals" case from the compact disk was included in compliance calculations if it was Title XIX/XXI eligible at referral and was free from errors in the Program Type, Referral Date, and Date of First Offered Appointment fields. For these 54,447 cases, the number of days between the Referral Date and Date of First Appointment Offered was calculated, as shown in Table 2.

Table 2
Access to Care: Appointment Availability for Routine Assessment
State-wide Compliance Rates Using the Universe of Data

Quarter	Total Referrals	Appointments Available Within 7 Days of Referral	Appointments Available Exceeding 7 Days of Referral	Percentage of Appointments Available Within 7 Days of Referral
1	14,013	13,535	478	96.59%
2	13,602	13,114	488	96.41%
3	13,764	13,558	206	98.50%
4	13,068	12,814	254	98.06%
TOTAL	54,447	53,021	1,426	97.38%

Of the 54,447, a total of 53,021 (97.38%) were found to have had routine assessment appointments scheduled within seven (7) days of referral or request for services during CY 2006.

These referrals for routine assessment were further stratified into adults and children. Adults were identified using referrals with Program Types "S," "M," or "G," whereas children were identified using Program Types "C" or "Z," in accordance with the ADHS/DBHS Performance Improvement Specification Manual.[4] There were an additional 134 cases with Program Types of "A," "D," and "Y," and they were assumed to be errors and omitted. Table 3 shows the compliance rates by age category.

Table 3
Access to Care: Appointment Availability for Routine Assessment
State-wide Compliance Rates by Age Category Using the Universe of Data

Age Category	Total Referrals	Appointments Available Within 7 Days of Referral	Appointments Available Exceeding 7 Days of Referral	Percentage of Appointments Available Within 7 Days of Referral
Adult	32,255	31,483	772	97.61%
Child	22,058	21,409	649	97.06%

Table 3 shows that the percentages of routine assessment appointments available within seven (7) days were similar for adults and children, and were above Benchmark standards state-wide for this measure during CY 2006.

The "CY 2006 Total Referrals" Compact Disk received from ADHS contained a field for the date when the appointment for routine assessment actually occurred, in addition to the date when the routine assessment appointment was first offered. This was not a mandatory field, and 1,783 cases could not be used for analyses due to errors or blanks.

Thus, 52,664 of the 54,447 cases were used for additional analysis involving when routine assessment appointments actually occurred. The distribution across days was examined for the 1,426 cases of the 54,447 total who did not have their appointment scheduled within seven (7) days, and this was computed for the 15,219 of 52,664 total usable cases whose actual appointment did not occur within the first seven days after referral, as shown in Table 4.

Table 4
Comparison of Time Distribution for the Days From Referral to the First Offered Appointment and the Days from the Referral Before the Routine Assessment Appointment Actually Occurred

Date of First Offered Appointment				Date of Actual Appointment		
Number of Days	Number of Referrals	Proportion of Referrals to Total Number		Number of Days	Number of Referrals	Proportion of Referrals to Total Number
1-7	53,021	97.38%		1-7	37,445	71.10%
8	359	0.66%		8	2,903	5.51%
9	166	0.30%		9	1,590	3.02%
10	142	0.26%		10	1,352	2.57%
11-13	290	0.53%		11-13	3,438	6.53%
14-16	179	0.33%		14-16	2,414	4.58%
17-20	140	0.26%		17-20	1,527	2.90%
21-30	99	0.18%		21-30	1,444	2.74%
31-63	44	0.08%		31-63	519	0.99%
64+	7	0.01%		64+	32	0.06%
Total	54,447			Total	52,664	

Table 4 shows that 97.38% of routine assessment referrals were offered an appointment within seven (7) days of referral, but only 71.1% of these actually had the appointment for routine assessment with seven (7) days of referral or request for service. Thus, although they were offered a first appointment for routine assessment within seven (7) days, over 25% did not actually have their appointment in that time frame. It took 20 days from referral for 96.2% to actually have the appointment for routine assessment.

D. Assessment of Strengths and Weaknesses

There were many data limitations in the analyses provided. The data and source documents requested for validation purposes were not available in the necessary timeframe. It is unclear why these problems occurred, but it may relate to the transitions during CY 2006 in how these data were collected, analyzed, and reported.

A strength of this performance measure, which exceeded the benchmark performance standard, is that it is indicative of the sufficiency of the provider network, which is of utmost importance in the provision of behavioral health services. A weakness is the extent to which it may be confused with actual receipt of the requested services. While it appears that the scheduling of routine assessment appointments occurred at very high

rates, there are indications that the actual receipt of services occurred at lower rates by comparison.

Transitioning to standardized electronic systems for submission of the data required to compute this measure, for calculating error rates, and for analysis is a strength as long as periodic auditing processes occur for validation purposes. The sampling process used in the past has been a weakness because it is susceptible to having too small a sample at the end of the year if referrals during a given year are greater than in the year before.

A strength of having the electronic data necessary to compute the measure is that sampling should no longer be needed. Calculating the measure using the universe of data should be less costly and time-consuming than sampling and there will be no need to consider confidence levels and margins of error as the computations will involve the entire study population.

E. Conclusions

The EQRO cannot conduct validation of this performance measure due to the following.

1. ADHS/DBHS was not able to provide hard copy of the referral logs for the EQRO to validate.
2. The quarterly submittal data cannot be compared to the universe of data because two of the quarters had invalid data, which included Non-Title XIX/XXI members. This data was used in quarterly calculations and then removed for universal calculations, thereby resulting in two different formulas to ascertain compliance rates.
3. The actual number of cases removed due to errors was excluded from the quarterly data but not the universe of data. Thus, the EQRO could not ascertain whether the sample size was statistically significant to accurately reflect compliance rates.

The differences were more pronounced in Quarter 1 and Quarter 2, but, as previously discussed, the data from samples for Quarter 1 and 2 inappropriately contained some non-Title XIX/XXI members and these were removed before ADHS/DBHS provided the universe of data to the EQRO. The state-wide CY 2006 annual state-wide compliance rate was 95.5% using sample data, and 97.38% using the universe of data. This difference is within the 5% margin of error projected when sample sizes were determined. State-wide annual compliance rates for routine assessment appointments scheduled within seven (7) days of referral exceeded the Benchmark Performance Standard in CY 2006.

F. Recommendations

The section of the Performance Improvement Specification Manual for the access to care measure for routine assessments needs to be reviewed, corrected, and expanded to include detailed operational definitions for the performance measure, formula for

calculation of error rate, inclusion and exclusion criteria, data collection procedures, and methods of analysis.

Consideration should be given to calculating the measure using the universe of data rather than sampling.

While the access to care appointment availability for routine assessment measure is useful for assessing the sufficiency of the provider network, it does not measure actual utilization of services. DBHS should consider using the current "unrequired data field" that indicated the date the first appointment actually occurred. This data field actually revealed the true outcome of the access to care because it indicated the actual initiation of services. The results of this field revealed that 96.2% of the time it took 20 days from the referral for the actual routine assessment to occur. This information lends itself to a performance improvement project focused on increasing the actual time of service initiation. Furthermore, because it is not a nationally standardized measure, comparisons of results with Title XIX populations in other states is not possible.

The addition of one or more nationally standardized measures of access to care is recommended. The National Quality Measures Clearinghouse lists several access measures based on utilization of services.[5] Measures of access to behavioral health services have been incorporated into performance measures proposed by a variety of national groups including the American College of Mental Health Administration 1997 Santa Fe Summit on Behavioral Health,[6] the Mental Health Statistics Improvement Project (MHSIP) Consumer Oriented Mental Health Report Card[7], the National Association of State Mental Health Program Directors President's Task Force on Performance Measures,[8] and the Center for Mental Health Services' 2001 Report to the Surgeon General.[9]

References

[1]Centers for Medicare & Medicaid Services, Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. February 11, 2003.

[2]Arizona Health Care Cost Containment System Administration, Division of Business and Finance, Contract Number YH8-0002, Contract Amendment 29, November 1, 2005.

[3]Arizona Department of health Services, Division of Behavioral health Services, Final Study Report, Access to Care Performance Improvement Project, January 16, 2007.

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III. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE IMPROVEMENT PROJECT

ACCESS TO CARE: APPOINTMENT AVAILABILITY FOR ROUTINE ASSESSMENT

A. Objectives

The behavioral health Performance Improvement Project (PIP) selected by AHCCCS for External Quality Review in CY 2006 was access to care: appointment availability for routine assessment within seven (7) days of referral or request for behavioral health services. This PIP performance measure is aligned with the second of the three parts of the appointment standards measure required under the AHCCCS contract with ADHS/DBHS.[1]

The AHCCCS Medical Policy Manual defines a PIP in Chapter 900 as "a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery." Policy 980, Chapter 900, contains selection and assessment criteria for PIPs, and policy 990 stipulates PIP reporting requirements.[2]

Conducting a PIP includes 10 steps as follows.[3]

- Selecting the study topic(s) for improvement
- Defining the study question(s)
- Selecting the study indicator(s), also referred to as the performance measure(s)
- Using a representative and generalizable study population
- Using sound sampling techniques, if sampling is used
- Reliably collecting data
- Implementing intervention and improvement strategies
- Analyzing data and interpreting PIP results
- Planning for "real" improvement, such as calculating the degree to which an intervention produces statistically significant changes
- Achieving sustained improvement

AHCCCS established the following timeframes for PIPs.[4]

- The first year is when baseline measurement data are collected and submitted
- The second year is the intervention year, and no PIP report is due
- The third year is the re-measurement period that will demonstrate if performance has improved since baseline
- The fourth year is another re-measurement year to determine the sustainability of the results of the performance improvement interventions

AHCCCS and ADHS/DBHS established the Access to Care: Routine Assessment performance measure in July 2002 to evaluate the timeliness of routine assessment services provided to Title XIX/XXI members. AHDS/DBHS initiated the PIP with this measure as the performance indicator in January CY 2003.

A Project Workgroup was formed under the direction of the ADHS/DBHS Medical Director and included Quality Management representatives from ADHS/DBHS, RBHAs, and providers. The workgroup met quarterly and assumed the responsibility for the PIP goal of assuring that the Minimum Performance Standard of 85% compliance rate was met at the RBHA and state-wide levels for scheduling routine assessment appointments within seven (7) days of request or referral.

This goal was achieved during all four quarters at the state-wide level in the second year of the PIP (CY 2004), but two of the RBHAs had compliance rates less than the goal in two or three of the CY 2004 quarters. During CY 2005, one of these two RBHAs brought their compliance rates above the minimum required, and the second RBHA also had compliance rates above the minimum the first two quarters, before having rates below the minimum again the last two quarters. A third RBHA just missed the minimum compliance rate standard in one quarter. Even with these deficiencies, the state-wide compliance rate in the third year of the PIP (CY 2005) was above 85% one quarter and above 90% the other three quarters.

Given this progress, the Project Workgroup raised the PIP goal, aiming that RBHAs should meet and exceed the Performance Goal of 90% and subsequently the Performance Benchmark of 95% in CY 2006, the fourth year of the PIP. These goals were achieved during each of the last two quarters of CY 2006, both at the RBHA and at the state-wide level.[5]

In addition to reviewing the availability of routine appointments within the prescribed time frame, the Project Workgroup proposed two other objectives for this PIP. One was to identify barriers to appointment availability, and the other was to develop a mechanism for systematic reporting of appointment availability across RBHAs. These two objectives were also met, as discussed in the following sections.

B. Description of Data Collection Methodology

Initially, the performance measure was calculated based on RBHA/subcontractor referral logs submitted to ADHS/DBHS each month and aggregated for the quarter. The logs contained specified fields pertaining to all members referred for routine behavioral health services. During the baseline measurement period, some providers had difficulty accurately capturing all the elements needed to calculate the performance measure such as referral date, appointment offered date, and Title XIX/XXI status.

To address this problem, Access To Care Referral Log Specifications and a Uniform Referral Log Column Layout were developed to improve data quality.[6] ADHS/DBHS Quality Management began calculating error rates for RBHA referral logs in Autumn

of 2005. The percentage of data errors and blanks were calculated on a monthly and quarterly basis in an effort to improve data quality and integrity.

Formal actions were taken for errors in excess of five (5)% for two consecutive quarters. ADHS/DBHS Quality Management also required RBHAs to perform an analysis when there was a decrease of five (5)% or more in performance on this measure from one quarter to the next and an improvement plan was required in such instances to assure sustainability of performance.

As of the second quarter of CY 2006, RBHAs submitted the information previously contained in the referral logs to ADHS/DBHS in Comma Delimited Text Format and according to the ADHS/DBHS Access to Care Referral Log specifications and file layout. These data were placed on the network server where they could be accessed by both ADHS/DBHS and the RBHAs. The Referral Log Column Layout contained the following fields.[6]

- Title XIX/XXI
- Program Type
- Referral Source
- Client Last Name
- Client First Name
- Date of Birth
- Behavioral Health Services Client ID
- Referral Date
- Date of First Offered Appointment
- Date of Actual Appointment
- AHCCCS Provider ID

According to the ADHS/DBHS Performance Improvement Specification Manual, four (4) fields were mandatory, and were flagged to denote any errors as follows.[6]

- Title XIX/XXI if blank
- Program Type if blank
- Referral Date if the date had an error or was blank
- Date of First Offered Appointment if the date had an error or was blank

Errors in any of these mandatory fields resulted in the referral not being included in the sample, and thus not included in computation of compliance rate.

The formula for calculation of error rate was shown in the ADHS/DBHS Performance Improvement Specification Manual, for the performance measure Access to Care: Appointment Availability for Routine Assessment, as follows.[6]

*Error rate = Number of Field Errors / Number of Referrals * Number of Fields (10)*

The EQRO questioned the face validity of this formula, as it is thought to greatly overestimate the proportion of errors, and requested additional information. A sample error report subsequently obtained for a single RBHA for June 2006, however, contained a different formula, which appears to be the actual formula used for total percentage of error calculation. That formula is as follows.

*Total % of error = Number of field errors / (Number of fields * Number of referrals)*

Assuming that the number of fields is 10, the parentheses around the denominator in the second example produces a rate that is less than, by a two decimal point difference, the rate calculated by the first formula where there are no parentheses around the denominator. Moreover, as the error rate is consistently reported as a percentage, the precise formula used for computing total error rate is presumed to be as follows, assuming the number of fields is 10 and substituting "X" for the "*" used to denote "multiplied by" in Excel software.

Total percentage of error =
100 X [Number of field errors / (Number of fields X Number of referrals)]

A question remains whether referrals with errors in one of the four (4) mandatory fields were excluded from compliance rate calculation, or whether referrals with errors in any of the 10 fields were excluded.

C. Description of Data

The performance indicator was percentage of referrals offered behavioral health appointments within seven (7) days of referral or request for routine assessment.

Numerator: Number of sample referrals that met the requirement of appointment availability within seven (7) days

Denominator: Total number of sample referrals reviewed

Results were compared with the established standards for compliance as follows.

- 85%: Minimum Performance Standard
- 90%: Goal
- 95%: Benchmark

D. Review of Analysis Methodology

ADHS/DBHS reviewed the referral logs and generated a monthly sample for each RBHA. Data from these monthly samples were analyzed and the results placed in electronic server that RBHAs could access to review and improve performance.

An annual sample size was calculated based on referral numbers reported by each GSA for the previous fiscal year. The annual sample size was divided by four (4) to obtain the quarterly sample. Each quarter a sample was drawn, by a sampling procedure using every *n*th case, for each GSA that included all Title XIX/XXI adults and children who were referred for service during the quarter.

ADHS/DBHS split the sample size proportionately for children and adults in order to assess accessibility issues specific to children. As of July 2005, samples were selected using a computer program, and referrals with errors in mandatory fields were omitted when samples were drawn electronically.

Monthly data were aggregated and analyzed for quarterly reporting to AHCCCS through the Quarterly Contractor Performance Improvement Activity Reports. Data were also aggregated on an annual basis for yearly review of the performance indicator, at which point the plan was to have had a statistically valid sample size. This presented a problem in instances where the number of referrals in a given year was substantially more than in the previous year. This situation occurred during CY 2006, and sample sizes for the third and fourth quarters were re-calculated based on referral numbers for the previous four quarters.

According to the Quarterly Contractor Performance Improvement Activity Report for the fourth quarter of CY 2006, ADHS/DBHS will use a different methodology for selecting samples for this measure of CY 2007. Under the new methodology, sample sizes will be based on quarterly rather than annual referral numbers.

For CY 2003 and CY 2004, the size of the samples for each GSA was calculated in order to produce a 90% confidence level and 5% margin of error. In July 2004, at the beginning of CY 2005, the confidence level was increased to 95% with a 5% margin of error for the remainder of the PIP.

Compliance rates were calculated for the sample populations by using referrals that were identified as Title XIX/XXI members who had no errors in other mandatory fields. Sample referrals were further stratified by adults and children. The number of days between the referral date and the date of the first offered appointment was calculated by subtracting the referral date from the offered appointment date. The percentage of referrals that were in compliance and out of compliance was calculated as follows.

- Referrals with $\leq$7 days from referral date to first appointment offered date were in compliance
- Referrals with $\geq$8 days from referral date to first appointment offered date were out of compliance

Quarterly state-wide compliance rates for scheduling appointments for routine assessments within seven (7) days of referral were taken from the ADHS/DBHS Final Study Report for this PIP and depicted in Figure 1.[5]

Figure 1: State-wide Compliance Rate
Availability of Appointment for Routine Assessment
Within 7 Days of Referral

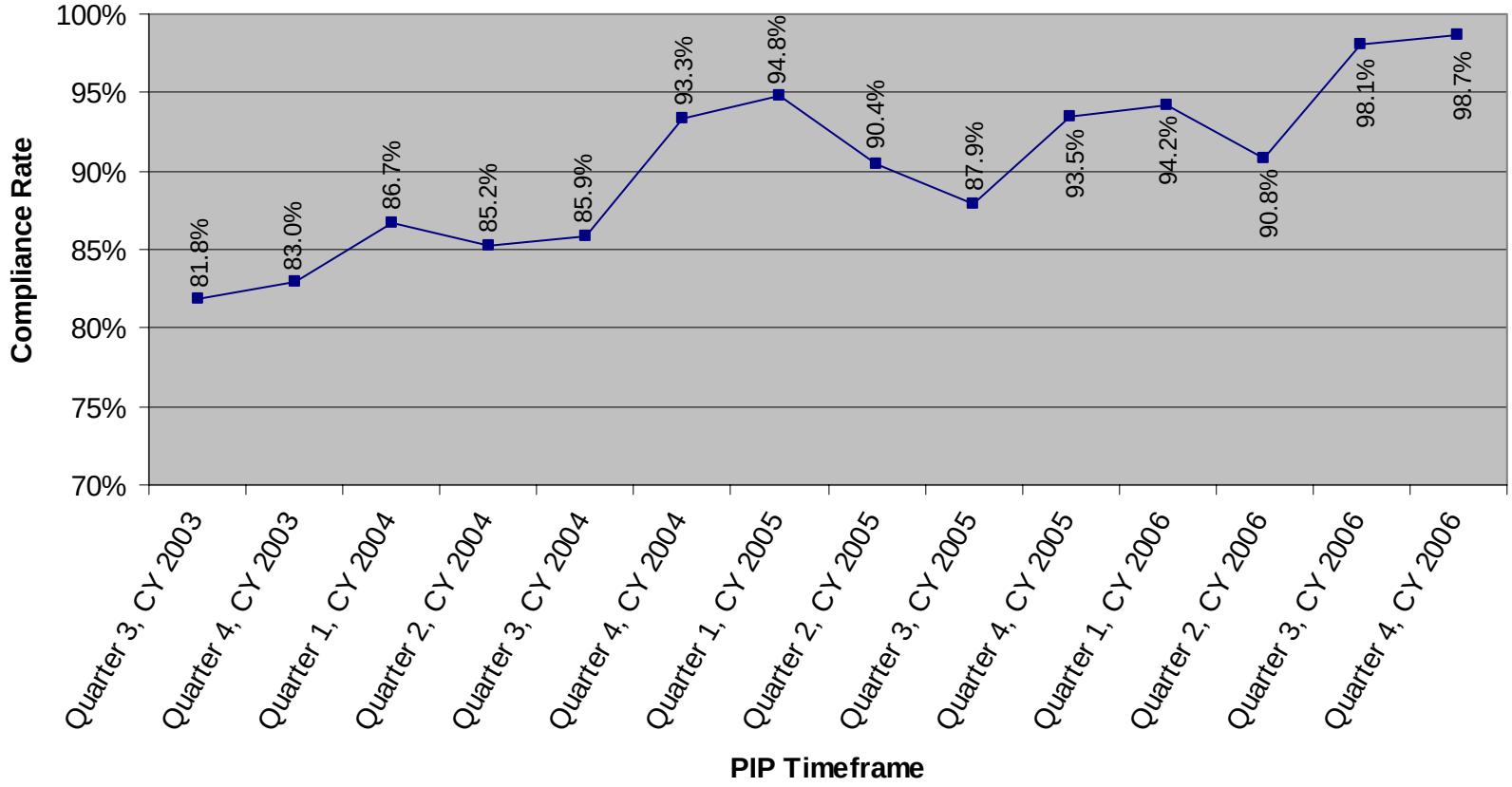

Figure 1 shows the overall state-wide increase in compliance rates over the PIP time frame. Starting with the first year of PIP interventions, there was an increasing trend in meeting and exceeding the Minimum Performance Standard (85%) and the Performance Goal (90%) for routine assessment appointment availability within seven (7) days of referral.

According to the Final Study Report, the state-wide compliance rate during the baseline year (CY 2003) was 77.47%. State-wide compliance rates increased across each of the three subsequent years when performance improvement interventions were implemented. The yearly state-wide compliance rate was 87.79% in CY 2004, 91.46% in CY 2005, and 95.5% in CY 2006.

As a means of testing the representativeness and reliability of the ADHS/DBHS data, the EQRO recalculated compliance rates from data for the universe of members who were referred for or requested routine assessments in CY 2006. Both the ADHS/DBHS and EQRO calculations resulted in state-wide compliance rates above 98% for the last two quarters of CY 2006, and the slight differences in rates were well within the margin of error specified by ADHS/DBHS. A more extensive discussion of performance measure validation can be found in Section II of this report.

The Project Workgroup identified several barriers to improving and sustaining compliance rates including data collection, staffing, resources, planning, capacity, and efficiency. The Workgroup chose to focus on data collection, no show rates, and capacity issues as the most expedient and effective ways to enhance compliance.

Strategies to combat no show rates have included overbooking to better utilize available time, reminder calls, extending office hours, and having designated intake days and staff. An ongoing intervention has been the provision of training and technical assistance, including provider site visits to review the referral process, assessment process, tracking of data, policies, and procedures.

The Project Workgroup concluded that the Access to Care: Appointment Availability for Routine Assessment PIP had demonstrated that high compliance rates had been achieved at RBHA and state-wide levels on a sustainable basis and that the goals and objectives of the PIP had been met over the time frame from CY 2003 through CY 2006. Thus, the PIP was completed as of the end of CY 2006.[5]

E. Assessment of Strengths and Weaknesses Related to Quality of Care, Timeliness, and Access

The consistent involvement, oversight, and monitoring by the Project Workgroup was integral to the success of this PIP. The Access to Care Performance Improvement Project Workgroup met quarterly and reviewed data to determine strategies to improve and sustain compliance rates. Specialized support and technical assistance was given to outlier RBHAs and providers.

A strength of this PIP is its alignment with an existing performance measure that is routinely analyzed and reported. The Project Workgroup recognized that problems associated with provider capacity and gaps in monitoring activities are likely to continue to be encountered by RBHAs, particularly as the PIP demonstrated that high compliance rates in a given quarter or quarters would not ensure high compliance rates in the following quarters. It is a strength that ADHS/DBHS will continue to analyze this performance measure and report it to AHCCCS on a quarterly basis. ADHS/DBHS has committed to the following activities to assure that decrements in performance are identified and dealt with.[5]

- Continuing to monitor RBHA's and providers' performance on a monthly and quarterly basis and follow-up on the implementation of interventions regarding outliers
- Identifying and disseminating strategies and best practices and providing technical assistance as needed to enhance and ensure that high compliance rates are sustained
- Reconvening the Project Workgroup as deemed necessary to discuss problems that may arise and explore potential interventions

An opportunity for improvement for ongoing and future PIPs was recognized during the external review process. The operational definitions crucial to precision in conducting PIPs could not be located in one source document. This pertained to definitions of the study population, data collection procedures, and methods of evaluation. Rather, some information was in the PIP plan, some in the PIP Final Study Report, some in the Quarterly Contractor Improvement Activity Reports, some in the Performance Improvement Specification Manual, and so forth. Moreover, some needed information was not located in any of these sources, and some definitions, criteria, and data were inconsistent between sources.

The methodology of using the number of referrals from the year prior to a contract year to project the sample size needed during that contract year was a source of weakness that continued to be problematic. According to the Quarterly Contractor Performance Improvement Activity Report for the fourth quarter of CY 2006, ADHS/DBHS will use a different methodology for selecting samples for this performance measure of CY 2007. Under the new methodology, sample sizes will be based on quarterly rather than annual referral numbers according to the quarterly report.[7]

The EQRO is uncertain why sampling is still being planned when the universe of appointment availability for routine assessment data is now available electronically. Sampling can only provide an estimate of a given measure within a proscribed confidence limit and margin of error, and is used where computation of the measure in any other way would be too time-consuming and expensive. There does not appear to be a reason to use sampling when the measure can be computed electronically from the universe of data, assuring an accurate representation of the findings.

F. Conclusions

This PIP achieved the initial goal of assuring that the Minimum Performance Standard of 85% compliance was met at the RBHA and state-wide levels for scheduling routine assessment appointments within seven (7) days of request or referral. Further, barriers to appointment availability were identified, strategies for compliance were planned, interventions were implemented, and compliance rates continued to improve over the PIP timeframe. Best practices for compliance and sustainability were summarized that will continue to be beneficial to improving access to care and may be generalizable to other situations where improving performance is a priority. Additionally, a mechanism for systematic reporting of electronic appointment availability data across RBHAs to ADHS/DBHS was developed and implemented as a result of this PIP. This uniform system of data collection and aggregation is expected to greatly improve the timeliness, accuracy, and quality of data.

G. Recommendations

Attention needs to be given to the importance of precision and thoroughness in stipulating operational definitions of the study question(s), study population(s), definition of performance measure(s), inclusion and exclusion criteria, data collection procedures, and methods of analysis. These should be defined and aggregated in a single source document that is revised over time as any changes occur. Tracking of such changes and when they were introduced is important. Additionally, periodic review of the consistency of information across various documents and systems that are used for computations, analyses, and reports is recommended. The technical specifications that accompany a set of standardized measures such as those used for HEDIS® provide a model for consideration.[8]

Using the universe of electronic data now available for analyzing the compliance rates for appointment availability for routine assessment within seven (7) days of referral is recommended. Compared to sampling procedures, this will save time and money and provide a much more accurate representation of the findings.

The oversight and monitoring provided by the Project Improvement Workgroup, with participation by appropriate persons from ADHS/DBHS, RBHAs, and providers, should be considered a model for conducting a PIP. The strategies and best practices for compliance and sustainability should be shared across the behavioral health system to recognize their effectiveness and provide lessons learned that are broadly applicable.

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[1]Arizona Health Care Cost Containment System Administration, Division of Business and Finance, Contract Number YH8-0002, Contract Amendment 29, November 1, 2005.

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IV. REVIEW, ANALYSIS, AND SUMMARY OF THE AHCCCS ORGANIZATIONAL ASSESSMENT AND STRUCTURAL PERFORMANCE OF ADHS/DBHS TO DETERMINE COMPLIANCE WITH MEDICAID MANAGED CARE FEDERAL AND STATE REGULATIONS

A. Objectives

An annual Operational and Financial Review (OFR) is used by AHCCCS to monitor and evaluate ADHS/DBHS compliance with Medicaid managed care federal and state regulations pertaining to behavioral health services. The CY 2006 OFR, for July 1, 2005 through June 30, 2006, was conducted by AHCCCS from October 10 through October 12, 2006. AHCCCS transmitted the final CY 2006 OFR report to ADHS/DBHS on January 17, 2007.[1] The ADHS/DBHS Corrective Action Plan (CAP), required to address the OFR recommendations, was received by AHCCCS February 20, 2007.[2]

To ensure ADHS/DBHS' operational and financial program compliance with its contract with AHCCCS, the OFR review team's activities were as follows.[3]

- Determining if ADHS/DBHS satisfactorily met AHCCCS requirements as specified in contract, policy, and rule
- Reviewing the progress made toward implementing the recommendations made during the previous review
- Reviewing outcomes of interventions for performance measures and performance improvement projects
- Reviewing records of appeals for timeliness and appropriateness
- Determining if ADHS/DBHS was in compliance with its policies and procedures, and evaluating the effectiveness of those policies and procedures
- Providing technical assistance and identifying areas in which improvements could be made, as well as identifying areas of noteworthy performance and accomplishment
- Conducting interviews or group conferences with members of ADHS/DBHS' administrative staff
- Examining records, books, reports, and information systems of ADHS/DBHS or its subcontractors as necessary

The OFR process used by AHCCCS in consistent with the mandatory protocol for Monitoring MCOs and Prepaid Inpatient Health Plans (PIHPs),[4] as required by the CMS Final Rule on EQR of Medicaid Managed Care Organizations.[5]

B. Description of Data and Information Collection Methodology

The six (6) member AHCCCS OFR review team included staff from Behavioral Health/Acute Care Operations, the Office of Legal Assistance, and the manager of Acute Care Operations/Provider Relations. Fourteen (14) staff from ADHS/DBHS participated in the review. The OFR tool contained 49 standards/substandards from six (6) domains

or program areas. The program areas included Delivery System, General Administration, Grievance System and Member Rights, Quality Management, Utilization Management, and Recipient Services.[1]

AHCCCS required ADHS/DBHS to develop a CAP for most standard/substandard(s) where there were recommendations that some action must or should be taken. The CAP was due to AHCCCS for approval within 30 days of the final OFR report.

C. Description of Data and Information

Table 5, Figure 5, and Figure 5.1 illustrate the results of the behavioral health services CY 2006 OFR across the six (6) program areas reviewed.

Table 5: Behavioral Health CY 2006 OFR Results

Program Area	Total Number of Standards	Compliance Rating for Standard				
		Full	Substantial	Partial	Non-compliant	Not Rated
Delivery System	3	(1) 33.3%	(1) 33.3%	(1) 33.3%	(0) 0%	(0) 0%
General Administration	1	(1) 100%	(0) 0%	(0) 0%	(0) 0%	(0) 0%
Grievance and Member Rights	19	(17) 89.5%	(1) 5.3%	(0) 0%	(0) 0%	(1) 5.3%
Recipient Services	7	(5) 71.4%	(1) 14.3%	(0) 0%	(1) 14.3%	(0) 0%
Quality Management	8	(5) 62.5%	(0) 0%	(0) 0%	(3) 37.5%	(0) 0%
Utilization Management	11	(7) 63.6%	(0) 0%	(0) 0%	(4) 36.4%	(0) 0%
TOTAL	49	(36) 73.5%	(3) 6.1%	(1) 2%	(8) 16.3%	(1) 2%

Figure 5: Behavioral Health CY 2006 OFR Results for Program Areas

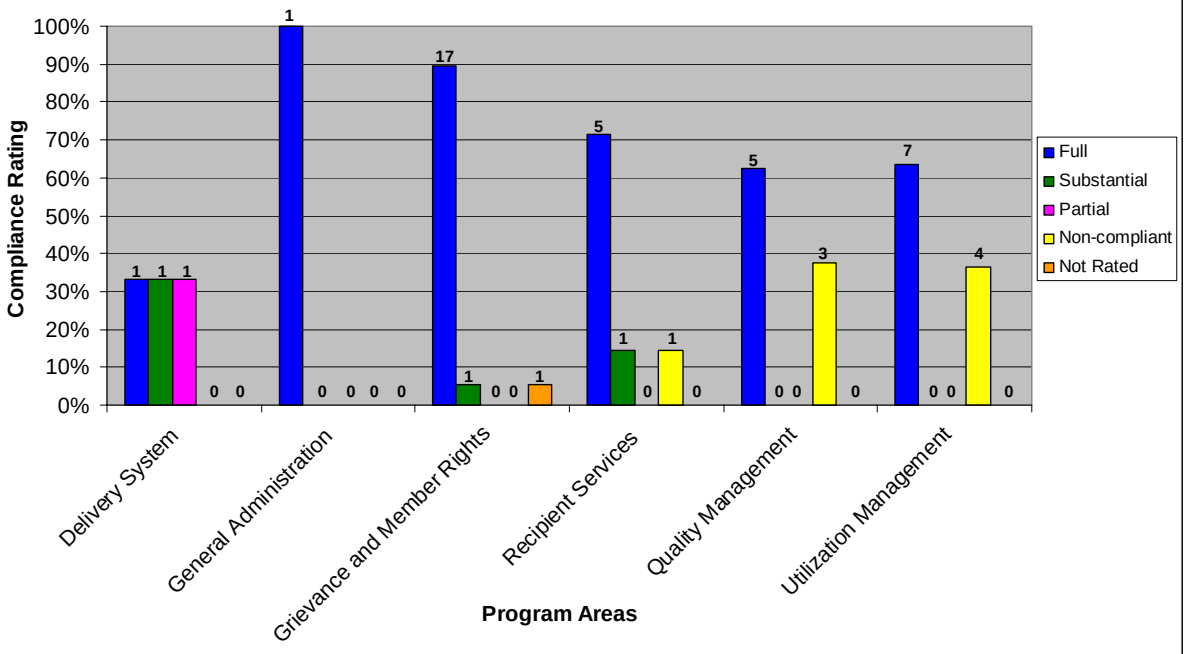
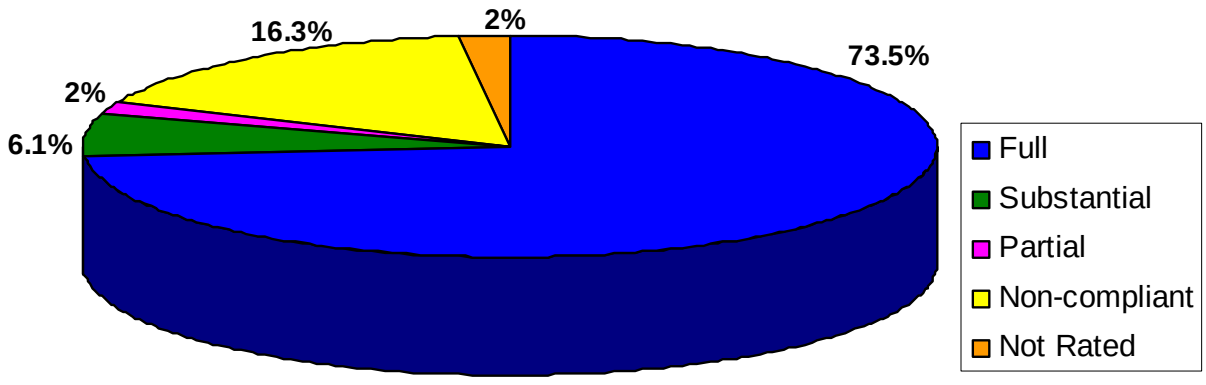


Figure 5.1: Behavioral Health CY 2006 OFR Results



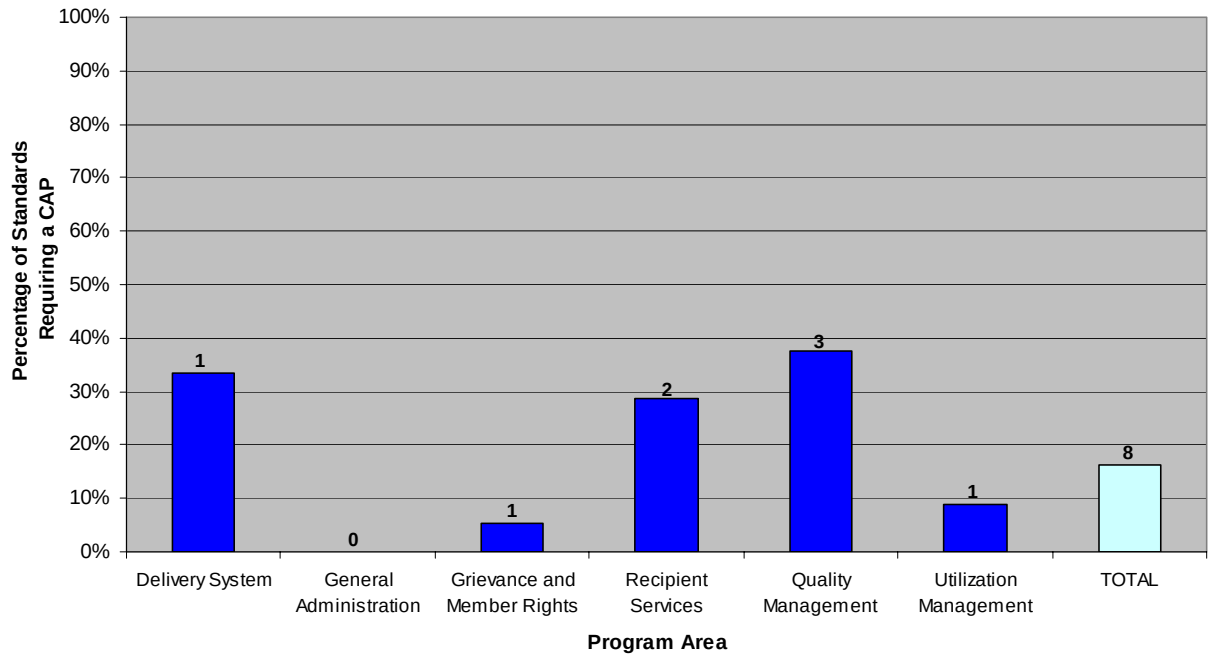
As shown in Figures 5 and 5.1, ADHS/DBHS was rated in full or substantial compliance in CY 2006 for 39 of the 49 standards/substandards, or 80%. One (1) substandard received a partial compliance rating, and one (1) was not rated. Non-compliance ratings were given in eight (8) instances. Seven (7) of the eight (8) ratings of non-compliance were in the Quality and Utilization Management areas, with Recipient Services receiving one (1) non-compliance rating.

The number of standards/substandards receiving recommendations is shown in Table 6 across the six (6) OFR program areas, and the percentage of standards/substandards requiring a CAP is graphically presented in Figure 6. There were a total of 13 OFR recommendations, with a CAP needed for eight (8) standards, or a total of 16.3%, as shown in Figure 6.

Table 6: Behavioral Health CY 2006 OFR Recommendations

Program Area	Total Number of Standards	Number of Recommendations	Number of Recommendations Requiring a CAP	Number of Standards Requiring a CAP	Percentage of Standards Requiring a CAP
Delivery System	3	2	1	1	33.3%
General Administration	1	0	0	0	0%
Grievance and Member Rights	19	1	1	1	5.3%
Recipient Services	7	2	2	2	28.6%
Quality Management	8	4	4	3	37.5%
Utilization Management	11	4	1	1	9%
TOTAL	49	13	9	8	16.3%

Figure 6: Behavioral Health CY 2006 OFR Corrective Action Plans



D. Review of Analysis Methodology

The OFR standards/substandards were rated based on the findings using the following thresholds.

- Full Compliance: 90 to 100% of the requirements were met
- Substantial Compliance: 80 to 90% of the requirements were met
- Partial Compliance: 70 to 80% of the requirements of the standard were met
- Non-Compliance: Less than 70% of the requirements were met
- Not Rated: ADHS/DBHS was waived from the requirements of the standard

E. Assessment of Strengths and Weaknesses Related to Quality of Care, Timeliness, and Access

The Delivery System, Recipient Services, and Quality Management program areas contained the standards/substandards most relevant to quality of care, timeliness, and access.

Each of the Delivery System standards/substandards was particularly relevant to access to care, and they affected timeliness and quality of care as well. ADHS/DBHS was required to ensure the sufficiency of its provider network to meet the behavioral health service needs of Title XIX/XXI members, as well as to ensure that second opinions were provided to behavioral health recipients.

A Substantial Compliance rating was given to the substandard requiring ADHS/DBHS to maintain a state-wide network of subcontractors and providers sufficient to provide all XXI/XIX services. While the OFR found that ADHS/DBHS did evaluate the sufficiency of its contractors' provider network intermittently, deficiencies were noted in maintenance of sufficient network capacity for provision of therapeutic foster care services and respite services. It should be noted that ADHS/DBHS reported an increase of therapeutic foster care services in each GSA in CY 2006, particularly in Maricopa County. However, specific data were not provided during the OFR process to substantiate that sufficiency of the therapeutic foster care or respite services were ensured. ADHS/DBHS was rated in Full Compliance for monitoring its contractors to determine if any material gaps or deficiencies in the provider network were addressed, as well as for monitoring to determine that anticipated changes to the network were reported in a timely manner.

A Partial Compliance rating was given to the OFR requirement that second opinions be provided to behavioral health recipients as required in the AHCCCS contract with ADHS/DBHS. It was found that second opinions were provided upon request, within or outside the network, at no cost to the recipient. ADHS/DBHS did not, however, provide evidence of monitoring to ensure that second opinions were provided by a qualified care professional registered with AHCCCS. ADHS/DBHS reported that this substandard was complied with, but did not provide documentation that the necessary monitoring was in

place to ensure that non-registered AHCCCS providers were not used for second opinions.

The Recipient Services program area also contained standards that affected access and quality of care. ADHS/DBHS received Full Compliance ratings for several standards/ substandards within the Recipient Services program area relating to competency in addressing behavioral health recipients' cultural needs and preferences. The OFR found evidence that ADHS/DBHS performed interim monitoring to assure that its subcontractors assessed recipient and family cultural preferences and that providers included such preferences in treatment planning, achieving the state-wide contractual performance standard of 80%.

ADHS/DBHS did take action when this aspect of performance did not meet the performance standard on a state-wide basis, and required a CAP for any subcontractor not showing demonstrable and sustained improvement. ADHS/DBHS monitored to determine its subcontractors assessed the cultural competence of the provider network and that their employees were provided with a cultural competency orientation and ongoing training.

The OFR documented that ADHS/DBHS ensured its subcontractors had a cultural competency development and implementation plan that met requirements and was reviewed and updated annually as necessary. ADHS/DBHS was found to have monitored its subcontractors to determine that behavioral health recipients were notified that oral interpretation services were available in any language without charge and how to access these services. Monitoring was further documented that these oral interpretation services were available as required.

ADHS/DBHS was found to have monitored to determine that contractors' employees had access to references listing resources for behavioral health recipients with diverse cultural needs. ADHS/DBHS monitored to determine its contractors translated all behavioral health recipient materials into prevalent languages, including the Member Handbook, Notices of Action, generic correspondence, and member newsletters.

The only Recipient Services substandard receiving a rating of Non-compliance was that ADHS/DBHS did not provide evidence of having monitored interpreter services for the hearing impaired as required.

Standards/substandards relating to quality of care were in the Quality Management program area of the OFR. ADHS/DBHS was found to be in Full Compliance with five (5) of the Quality Management standards/substandards, and in Non-compliance with three (3). ADHS/DBHS strengths in Quality Management are enumerated as follows.

- Monitoring the timeliness, completeness, accuracy, logic, and consistency of quality and utilization management data and reports to ensure the integrity of information and data reported to AHCCCS

- Analyzing and using grievance, appeal, expedited appeal, mortality, and incident/accident data as part of the quality management process and to inform decision making and improve the care of behavioral health recipients
- Monitoring each contractor's collection, analysis, and use of quality management and utilization management data to ensure that information was used to improve the quality of care to behavioral health recipients
- Having a process in place for reviewing and evaluating quality of care complaints and allegations
- Having a structure and process in place to track and trend quality of care concerns and abuse/complaint allegations

ADHS/DBHS weaknesses in Quality Management, resulting in ratings of Non-Compliance, were as outlined below.

- Not receiving timely and consistent data, particularly from two of its subcontractors
- Not calculating encounter-based performance measures accurately or completely
- Not resolving quality of care concerns/service issues raised by behavioral health recipients, contractors, subcontractors, and other parties involved

To its credit, ADHS/DBHS has continued to address data problems and other quality management concerns over the years by providing training and technical assistance. ADHS/DBHS has required that its contractors put in place a data validation process, submit encounters on a timely basis, reduce claims errors, and train and assist providers with correcting claims. To bolster these efforts, corrective actions have included sanctions, financial withholds, data validation, and chart audits.

F. Conclusions

The methods, conduct, and feedback processes of the AHCCCS behavioral health OFR of ADHS/DBHS were consistent with the CMS protocol for monitoring Medicaid MCOs and PIHPs. The OFR process was bolstered by the extensive crosswalk completed by AHCCCS to assure compliance with all federal and state regulations.

In CY 2006, 39 (80%) of the 49 standards/substandards were rated in Full or Substantial Compliance. In CY 2005, 97 (91.5%) of the 106 standards/substandards achieved Full or Substantial Compliance ratings.[6] In CY 2004, 81% of the 90 standards/substandards received one of these two top ratings,[7] and in CY 2003, it was 80% of the 77 standards/substandards rated as being in Full or Substantial Compliance.[8] It is not possible, however, to trend OFR performance over time, as the number, content, and rating system of standards/substandards have changed from year-to-year. For example, in CY 2006 there were 54% fewer standards/substandards than in CY 2005, and, starting in CY 2005, the criteria for achieving the compliance ratings were made more stringent than they were in CY 2004 and CY 2003.

In CY 2006, there was only one (1) standard/substandard that received a Partial Compliance rating, and one (1) that was Not Rated. All others fell at the extremes, with 39 (80%) of the 49 standards/substandards receiving a Full Compliance rating and eight (8) (16.3%) of the standards/substandards getting a rating of Non-compliance. The Non-compliance ratings were generally in areas where problems had also been identified in previous years. Although some progress in these areas has been noted, more must be done to resolve these issues, and ADHS/DBHS has submitted the required CAPs to effectuate improved compliance.

G. Recommendations

The AHCCCS OFR process included generating recommendations that must or should be met, with CAPs required in most cases. The CY 2006 OFR included the following recommendations.[1]

1. Delivery System

    - Ensure ADHS/DBHS contractors maintain a sufficient network for the delivery of therapeutic foster care and respite services for behavioral health recipients

2. General Administration

    - None

3. Grievance System

    - Ensure that a Notice of Appeal Resolution is issued for all appeals. All Notice of Appeal Resolutions must indicate the components required by rule and contract

4. Quality Management

    - Ensure that the encounter data received from ADHS/DBHS contractors is timely, accurate, complete, logical, and consistent
    - Ensure the completeness, accuracy, and consistency of encounter-based performance measures to ensure the integrity of information and data reported to AHCCCS
    - Provide evidence that the resolution of a concern is communicated to the behavioral health recipient/guardian or originator of concern as appropriate
    - Monitor and incorporate the development of successful intervention/ approaches into the ADHS/DBHS quality management program

5. Utilization Management

    - Demonstrate that the Medical Care Evaluation studies are used to improve member care services and assess provider performance

6. Recipient Services

    - Monitor to ensure ADHS/DBHS contractors have interpreter services for hearing-impaired behavioral health recipients contacting ADHS/DBHS and its sub-contractors
    - Ensure that ADHS/DBHS contractors meet the state-wide contractual performance of 80% regarding the requirement to obtain consent for prescribed psychotropic medications

One Delivery System recommendation and three (3) Utilization Management recommendations did not require a CAP due to actions already taken by ADHS/DBHS to ensure that the relevant standards/substandards are met in the coming year.

References

[1]AHCCCS, CY 06 Final Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, January 17, 2007.

[2]ADHS/DBHS Draft Corrective Action Plan, AHCCCS Operational and Financial Review, February 20, 2007.

[3]State of Arizona, Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, December 2006.

[4]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at CFR Parts 400, 430, et al, (Final Protocol, Version 1.0), February 11, 2003.

[5]Centers for Medicare & Medicaid Services, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations. Final Rule, (Federal Register, 68 (16): 3585-638), January 24, 2003.

[6]AHCCCS, CY 05 Final Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, March 6, 2006.

[7]AHCCCS, CY 04 Final Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, January 28, 2005.

[8]AHCCCS, CY 03 Final Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, February 6, 2004.

V. SUMMARY AND RECOMMENDATIONS

State Medicaid Agencies are required by The Balanced Budget Act (BBA) of 1997[1] to provide the Centers for Medicare & Medicaid Services with an annual external independent review of access to, timeliness, and quality outcomes of services provided by Medicaid Managed Care Prepaid Inpatient Health Plans (PIHPs). This external review must include three mandatory activities, including validation of a performance measure, validation of a performance improvement project, and determination of PIHP compliance with federal Medicaid managed care regulations.[2] AHCCCS, the Arizona State Medicaid Agency, contracted with HCE QualityQuest as the External Quality Review Organization to prepare the CY 2006 annual report on ADHS/DBHS, the PIHP for Medicaid managed behavioral health services in Arizona.

The performance measure selected for validation was Access to Care: Appointment Availability for Routine Assessment Within Seven (7) Days of Referral or Request for Behavioral Health Services. In its contract with ADHS/DBHS, AHCCCS established three levels of performance standards pertaining to this measure. The CY 2006 Minimum Performance Standard was 85%, the Goal was 90%, and the Benchmark was 95%. The performance improvement project (PIP) selected for external review had this access measure as the performance indicator. AHCCCS monitored ADHS/DBHS compliance with state and federal Medicaid managed care regulations through an annual Operational and Financial Review (OFR).

ADHS/DBHS subcontracts with a Regional Behavioral Health Authority (RBHA) in each of six (6) geographic service areas to either provide covered behavioral health services directly or to secure a network of providers to deliver behavioral health services to Medicaid-eligible members within their contracted area.

The data source for the access to care for routine assessment performance measure has historically been the paper RBHA provider referral logs. Starting in CY 2006, however, RBHAs began compiling the data electronically for submission to ADHS/DBHS. Computation of the measure was performed from random samples of data without errors, stratified by RBHA and by age group (adults and children). Sample size was calculated to allow a 90% confidence level and five (5)% margin of error at the RBHA level at the beginning of the PIP, and was later increased to a 95% confidence level and a five (5)% margin of error. Reporting of this measure was through Quarterly Contractor Performance Improvement Activity Reports. ADHS/DBHS required RBHAs to take corrective action for error rates in excess of five (5)%. For RBHAs whose error rate exceeded five (5)% for two consecutive quarters, ADHS/DBHS took corrective action, up to and including sanctions.

The Access to Care PIP had three objectives. The first objective was to improve the availability of routine assessment appointments within seven (7) days of referral. The second objective was to identify barriers to appointment availability and to implement interventions to increase the compliance rate. The third was to develop a mechanism for systematic reporting of routine assessment availability across RBHAs. Each of the three

(3) objectives was achieved within the 3.5 year PIP timeframe, and the PIP was closed at the end of CY 2006, even though the performance measure will continue to be monitored through quarterly reports. The last two (2) quarters of CY 2003 were the baseline measurement period, and the state-wide compliance rate for scheduling routine assessment appointments within seven (7) days of referral was 77.47%.

Barriers to routine assessment appointment availability were identified, including data collection, no show rates, provider capacity, and interventions were implemented. State-wide compliance rates continued to increase from the first intervention year through the two re-measurement years. The annual state-wide compliance rate computed from sample data was 87.79% in CY 2004, 91.46% in CY 2005, and 95.5% in CY 2006. The EQRO used the universe of routine assessment referral data to re-compute the annual state-wide compliance rate for CY 2006, finding it to be 97.38%. This compliance rate was even higher that the 95.5% rate computed from sample data, and it was within the 5% margin of error which the sample size was designed to provide. Additionally, a mechanism for systematic reporting of electronic appointment availability for routine assessment data across RBHAs to ADHS/DBHS was developed and implemented. This uniform system of data collection and evaluation is expected to greatly improve the timeliness, accuracy, and quality of data.

ADHS/DBHS was rated in Full or Substantial Compliance in the CY 2006 OFR for 39 (80%) of the 49 standards/substandards from six (6) program areas including Delivery System, General Administration, Grievance System and Member Rights, Quality Management, Utilization Management, and Recipient Services. There were eight (8) ratings of Non-Compliance, seven (7) in Quality and Utilization Management, and one (1) in Recipient Services. ADHS/DBHS submitted Corrective Action Plans to AHCCCS for eight (8) or 16.3% of the standards/ substandards.

Recommendations are as follows. The section of the Performance Improvement Specification Manual for the access to care measure for routine assessment needs to be reviewed, corrected, and expanded to include detailed operational definitions for the performance measure, formula for calculation of error rate, inclusion and exclusion criteria, data collection procedures, and methods of analysis. Other sections of the Performance Improvement Specification Manual should similarly be reviewed to assess improvement opportunities.

Now that electronic data are available for availability of routine assessment appointments, the measure should be computed from the universe of data rather than from samples. Concerns about the representativeness of samples are avoided when the entire universe of participants is included in the analysis.

While the access to care appointment availability for routine assessment measure is useful for assessing the sufficiency of the provider network, another nationally standardized process measure of access that focuses on utilization is recommended. An outcome access measure is currently available through the bi-annual consumer survey. The access to care availability of appointments for routine assessment was above

benchmark levels in CY 2005 and CY 2006, but the ADHS/DBHS 2005 Consumer Survey reported that only 75% of adults responded positively about access to services compared to 72% in the Youth Services Survey for Families.[3] This suggests there are important access to care issues that still need to be addressed.

Improving the timeliness and consistency of encounter data has been an OFR recommendation every year for the past four years. ADHS/DBHS has continued to address data problems and other quality management concerns over the years by providing ongoing training and technical assistance. ADHS/DBHS has required that contractors conduct data validation, submit encounters on a timely basis, reduce claims errors, and train and assist providers with correcting claims. Corrective actions have included sanctions, financial withholds, data validation, and chart audits. Consideration of a system of rewards for data timeliness, completeness, and accuracy is recommended.

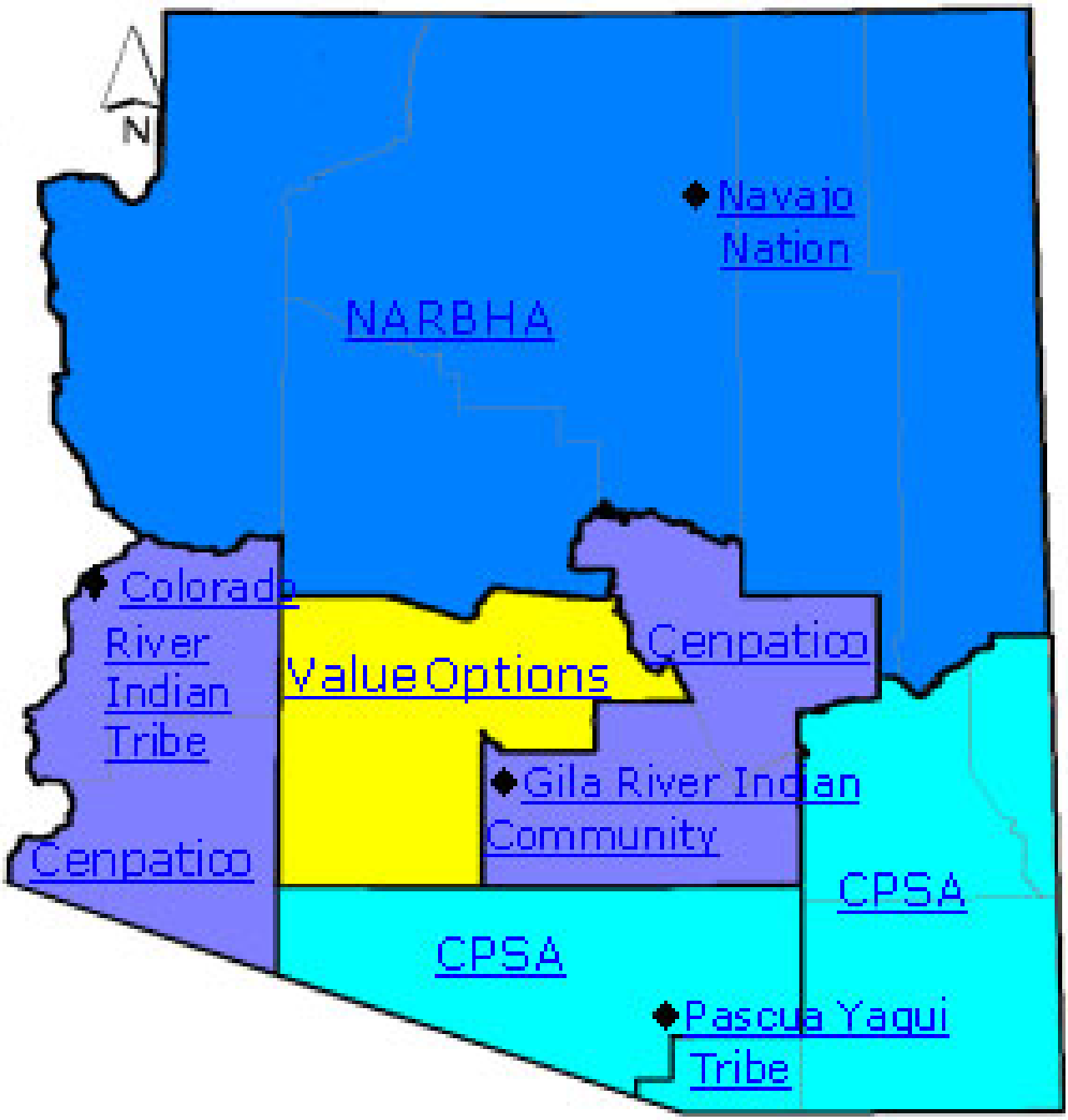
References

[1]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 - Managed Care. http://www.gpoaccess.gov/cfr/index.html.

[2]Centers for Medicare & Medicaid Services, Medicaid program; External Quality Review of Medicaid Managed Care Organizations (Final Rule. Federal Register, 68 (16): 3585-638), January 24, 2003.

[3]Arizona Department of Health Services, Division of Behavioral Health Services, 2005 Consumer Survey, June 30, 2006.

APPENDIX
AHCCCS Behavioral Health Services
CY 2006
Map of RBHAs



APPENDIX
AHCCCS Behavioral Health Services
CY 2006
Map of RBHAs